

# Patient's Authorized Representative Form

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You have the right to choose someone to act for you during your grievance/appeal. If you wish to have someone act on your behalf, fill out this form and send it to the address or fax number listed below. You can cancel this form by sending a request in writing. If you wish to have someone act for you and we do not get this form from you, your grievance/appeal may be closed.

## Patient Information

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient ID Number \_\_\_\_\_

## Authorized Representative

I give permission for \_\_\_\_\_ to act on my behalf and receive information about my grievance/appeal.

Address of the person acting on my behalf:

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Phone: \_\_\_\_\_ Fax (if prescriber): \_\_\_\_\_

Relationship:  Parent  Guardian  Conservator  Other: \_\_\_\_\_

## Patient Signature

By signing this form, PharmaForce PBM can release information to the person listed above about this grievance/appeal.

Mail or fax the completed form to:

PharmaForce PBM

Attn: Grievance & Appeals Coordinator

1950 Butler Pike, STE 262

Conshohocken, PA 19428

**Fax:** 844-550-2506

**Questions?** Call Customer Service at 866-660-5441

To cancel your grievance/appeal or authorized representative assignment, you can mail or fax a letter to same address.

I have read this form and agree to the terms.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient/Legal Guardian

\_\_\_\_\_  
Date